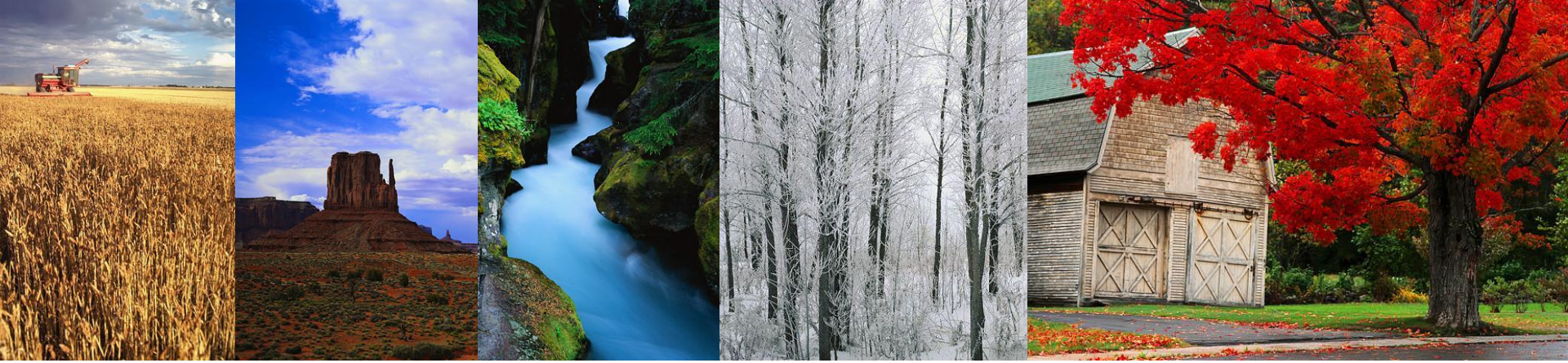


Observation Services

September 14, 2012 (Part 2)

RHPI
RURAL HOSPITAL PERFORMANCE IMPROVEMENT

Mary Guyot
Principal
mguyot@stroudwater.com

STROUDWATER ASSOCIATES

Objectives – Part 2

- **The participant will:**
  - Explain when condition code 44 is appropriate and what is the required process to apply such
  - Define a process for tracking and billing Observation hours
  - Review the requirement regarding “self-administered drugs” in OP
  - Discuss the physician’s responsibilities regarding Observation services and billing professional fee.
  - Discuss the chart content as a whole as well as recommended nursing documentation
  - Be able to facilitate a hospital-based team to determine level of compliance and facilitate an action plan

Changing Services from IP to OP and OP to IP

See Medlearn Matter re: CMS SE0622

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0622.pdf

Condition Code 44 (From IP to OP)

- In some instances, a physician may order an inpatient admission, but upon subsequent review, staff members determine that the inpatient level of care does not meet the Medicare IP's admission criteria.
- The National Uniform Billing Committee issued condition code 44 to identify cases when this scenario occurs and hospitals must change the patient's status from inpatient to outpatient.
- Providers should use this code on outpatient claims only
- Condition code 44 allows hospitals to treat the entire episode of care as an outpatient encounter and to receive payment under the outpatient prospective payment system.

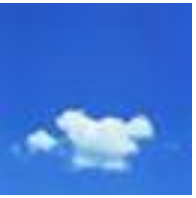
Condition Code 44 (From IP to OP)

- Providers should not use code 44 as a "catch-all" solution at the end of short stays when medical necessity is subsequently deemed unjustified after a patient is discharged.

- When an internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances, it would be appropriate to use condition code 44 if all other criteria are met

Condition Code 44 (From IP to OP)

- CMS set the policy for the use of condition code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager/UR is on duty to offer guidance.
  - This reinforces the need for UR to be involved in the decision making at a minimum during the daytime



Condition Code 44 (From IP to OP)

- Even if a physician orders that a patient be admitted to a hospital as an IP, CMS authorizes UR to change patient's **status from IP to OP if:**
  - The change is made while the patient is in the hospital
  - The hospital has not yet made a claim to Medicare for IP admission
  - A physician member of the UR committee determines the medical necessity and a treating physician concurs with UR's decision, and
  - The physician's concurrence is documented in the patient's medical records

Condition Code 44 (From IP to OP)

- A utilization review (UR) committee **(i.e., two or more practitioners or a QIO)** must determine whether admission criteria have been met once the clinical documentation improvement or case management team raises the question of whether the inpatient admission was appropriate

- The UR committee may review the medical record for inpatient admission criteria before, during, or after hospital admission but while the patient is still hospitalized

- At least two members of the committee must be MDs or DOs

- When the UR committee determines that the admission is not medically necessary, it must give written notification—within two days of the determination—to the hospital, the patient, and the practitioner responsible for the patient's care

Condition Code 44 (From IP to OP)

- The practitioner(s) responsible for the care of the patient must concur with the hospital's finding that inpatient admission criteria are not met.
  - This prerequisite for use of condition code 44 is consistent with the requirements in the CoP at §482.30 (d) of the regulations.
  - The practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary.
  - It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

- If the attending does not respond, or does not contest then the findings are final

- If the attending contests, at least one other physician member of the committee must review the case. If two physician members agree that inpatient is not medically necessary, the decision is final.

CMS FAQ re: Status Change

- **May a hospital change a patient's status using Condition Code 44 when a physician changes the patient's status without utilization review (UR) committee involvement?**

- **No**, the policy for changing a patient's status using Condition Code 44 requires that the determination to change a patient's status be made by the UR committee with physician concurrence. – This role may be based on a relationship with an affiliated hospital or outsourced

- **This physician member of the UR committee must be a different person from the concurring physician for Condition Code 44 use**, who is the physician responsible for the care of the patient. For more information, see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 1, Section 50.3.2 (When an Inpatient Admission May Be Changed to Outpatient Status)

Condition Code 44 (From IP to OP)

- With the **increased scrutiny** in today's regulatory environment of one-day admissions, UR and CDI (Clinical Care Improvement) personnel need to be diligent in reviewing physician documentation regarding appropriate inpatient criteria to support their admitting diagnosis.

- **To boost quality-of-care efforts and provide physician support, consider implementing the following at your facility:**
  - Encourage practitioners to proactively assist the UR committee in the decision-making process
    - Implement process for pre-review and approval as much as possible
  - Develop a quick reference tool for IP vs OP criteria based on the most frequent diagnosis seen at your hospital
  - ED physician education re: criteria and documentation
  - ED nursing and House Supervisor education if used
  - Clinic admitting MDs and office personnel as appropriate

Billing for Condition Code 44 (From IP to OP)

- When the hospital has determined that it may submit an outpatient claim according to the conditions applicable to the use of Condition Code 44, the hospital should report the entire episode of care as an outpatient encounter, as though the inpatient admission never occurred

- When a hospital submits a 13X or 85X type of bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital must report Condition Code 44 in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Condition Code 44 will be used by CMS and QIOs to track and monitor these occurrences.

Billing for Condition Code 44 (From IP to OP)

- ***Q:*** *How should the hospital bill Medicare if the criteria for using Condition Code 44 are not met, but all requirements in the condition of participation in §482.30 have been complied with?*

- **A:** If the conditions for use of Condition Code 44 are not met such as the need was identified at time of discharge or post discharge, the hospital should submit a bill using Type of Bill 12x for covered Part B Only services that were furnished to the inpatient.

Billing for Condition Code 44 (From IP to OP)

- Information about **Part B** only services is located in the *Medicare Benefit Policy Manual (Chapter 6, Section 10). Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and other services.*
- *The Medicare Benefit Policy Manual includes a complete list of the payable Part B Only services.*

Billing for Condition Code 44 (From IP to OP)

- While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as **for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter.**

- **For example**, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met.

Condition Code 44 - Recap

- Use Condition Code 44; IP admission changed to OP when UR staff, with the documented agreement of Medical UR advisor, determines that the IP did not meet criteria for such but does meet Observation criteria
- A dated and timed physician order is required to change the status of care to place patient in OP Observation
- The hospital cannot report hours of Observation services using HCPCS code G0378 (hospital observation service per hour) for the time period during the hospital encounter prior to a physician's order for Observation services.
- Hours for the time prior to the order should be reported by Revenue code only, no HCPCS
- **Medicare does not permit retroactive orders or the inference of physician orders**
- The clock time begins at the time that Observation services are initiated in accordance with a physician order

- On the outpatient claim on an uncoded line (no HCPCS code) with revenue code 0762, the hospital would report the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services.

- For other rules related to billing and payment of observation services, see Chapter 4, §290 and Chapter 6, §20.6 of the Medicare Benefit Policy Manual, Pub. 100-02.

- ***Q:*** *How should the change in patient status from inpatient to outpatient be reported in the patient's medical record? Can the hospital just discard the inpatient record?*

- **A:** Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

OP Observation to IP Admission Status Change

- **"Q:** What if an initial observation order was determined at later point in time to have been inappropriate as patient should have been admitted as an inpatient. What can be done?"

- **"A:** Orders cannot be retroactive therefore since order is written for inpatient care on different date than referral to observation, the admission date is the date the inpatient order is written, even if patient could have been inpatient when the observation order was written."

- **Note:** When an admission order is written but the patient status no longer supports the need for inpatient admission, the claim cannot be billed as an inpatient claim.

* Answer provided by the Noridian Administrative Services LLC who is the Medicare administrator contractor (MAC) for Arizona, Colorado, Montana, North Dakota, South Dakota, and Utah,

OP Observation to IP Admission Status Change

❑ PPS hospitals

- Given the 3-day rule applies, ED as Observation will be rolled into the IP stay but
- The 1st day in Observation will not count into the 3-day stay for SNF/SB referral since CMS does not allow rolling back admission time to the time they originally came in.

❑ CAH Hospitals

- Given that the 3-day rule does not apply to CAHs, the hospital will billed actual billable hours in Observation as well as ancillaries/procedures during that time.
- There will be a second bill for an IP stay effective the date and time of the physician's new order to change the patient from Observation level of care to IP admission.

Observation Time Calculation & Facility Billing

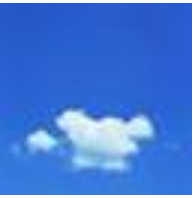
Assigning Account Number(s)

❑ CAHs

- 3-day rule does not apply
- Patient in ED and OBS has 1 account # and 1 UB-04
- If patient ends up being admitted, they will have 2 account # and 2 UB-04 (1 for OP and 1 for IP)

❑ PPS hospitals

- 3-day rule applies
- Patient in ED and OBS has 1 account # and 1 UB-04
- The ED and/or ED & OBS gets rolled into the IP stay therefore they only require 1 account #

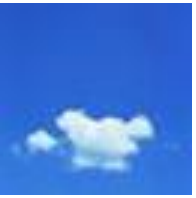


Bed Utilization on the IP Floor

- Outpatient services provided in "beds" or on the inpatient floor:
  - Observation
  - Therapeutic services – Chemotherapy, infusions, transfusions, etc.
  - Extended recovery
  - Packaged nursing care during an encounter (time included in the service)
  - Non-covered nursing care services

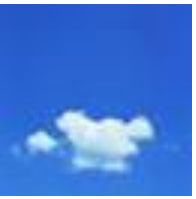
- CMS only pays for Observation when needed for 8 hrs or more (Effective Jan 1, 2011) in PPS hospitals – this does not apply to CAHs

- If patient had less than 8 hrs of Observation in a PPS hospital, the revenue code 0762 is used but with no HCPCS code for the # of hours the patient was cared for



Calculating & Billing Hours of Observation

- Calculating hours of Observation
  - Start with total hours in bed under nursing care
    - Minus time for procedures requiring active monitoring (see earlier section)
    - Minus hours where patient remains in bed but:
      - No longer in need of assessments and reassessments such as waiting for a ride
      - Monitoring for pre-op prep
      - Extended monitoring post procedure/surgery



Calculating & Billing Hours of Observation

- G0378 is billed per hour, rounded to nearest hour
  - 0 – 30 minutes = 0
  - 31 – 60 minutes = 1 unit
  - For example, a patient who began receiving observation services at 2:03 p.m. according to the nurses‘ notes and was discharged to home at 9:45 p.m. (total 7 hrs and 42 min) when observation care and other outpatient services were completed, should have a 8 placed in the units field of the reported observation HCPCS code if they were all active monitoring.
- Bill all billable hours for a single encounter on one line even if the Observation service spans more than a calendar day
  - (e.g.: Observation – 26 units) – that means 26 hrs on the line with date of when Observation was started)
- Bill all non-billable Observation hours on a second line
- The line-item date of service is the date the patient is admitted to observation care for both lines

Calculating & Billing Hours of Observation

- Use revenue **code 0762 with HCPCS** code G0378 for the total # of Observation hours meeting criteria when the patient is placed in Observation from the ED

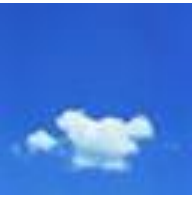
- Use revenue code **0762 with no HCPCS** code to report non-observational package nursing hours (hrs deducted from total hours due to active monitoring, extended nursing care etc)

- Observation hours provided prior to a condition code 44 inpatient review must be reported on the claim with no HCPCS G0378.

- Recommendation for CDM setup: In order to accomplish this, the CDM will need to have 2 lines to report Medicare Observation hours: for instance, one line for hours prior to condition code 44 review or active monitoring and one line to represent hours that can be reported with HCPCS

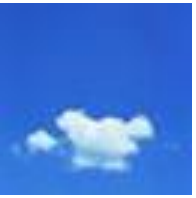
Description	RC	HCPCS	Fee
Observation per hour	762	G0378	Facility defined, the same fee applies for hours prior to and after UR review
Non-billable Observation hours	762		

Calculating & Billing Hours of Observation



- In addition, hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or hospital outpatient surgical procedure (status indicator T procedure) on the day of initiation of observation services.
- Hospitals should only report HCPCS code G0379 when a patient is referred directly for observation care after being seen by a physician in the community (see §290.4.2)
- The number of units reported with HCPCS code G0379 must equal 1
- In the situation above, the hospital still needs to report RC 0762 and G0378 for the # of Observation hours
- Ensure that G0379 and the hourly observation code G0378 both have the same date of service.

Other Info



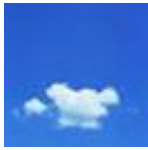
- **Patient may not be placed in Observation directly from home or nursing home without being seen by the physician on the day they were placed in Observation**

- For instance, if a family member calls the physician to discuss mom's status and the provider sent her to the hospital after calling to notifying you, the hospital may not bill for observation until he/she comes in to examine the patient and write the reason for placing the patient in Observation

- In the above case where the patient was not seen by the physician on the day they were referred to Observation, the Observation "start time" is only when the physician comes in to see the patient regardless of when the patient came in.

Billable Services and Supplies

- Report all services billable as OP services
  - Infusion (based on start and end time)
  - IV medication and Injections
  - Hydration
  - ECG
  - Catheter insertion, nursing procedures
  - Ancillary services – Lab, radiology, rehab
  - Respiratory therapy treatment
  - All procedures
  - Physical Therapy eval and units of treatment

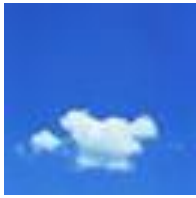


- Ensure physician documentation of the tests, procedures and treatments with support for why if not obvious and nursing documentation of such taking place

Facility Billing for Observation services

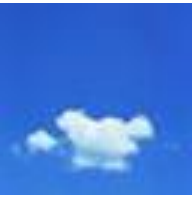
Frequently Missed Charges

- Injections (96372, 96374, 96375, 96376, 96409, 96411)
- Hydration therapy (96360–96361)
- Infusion therapy (96365, 96366, 96367, 96368, 96413, 96415)
- Fingerstick blood sugar (Accucheck) (82962)
- Straight cath for medical reasons (51701)
- Foley cath, simple (51702)
- Foley cath, complicated (51703)
- Cath for specimen collection only (P9612)
- Guaiac/fecal occult test (82270, 82272, 82274, G0328)
- Collection of blood through completely implanted VAD (36591)
- Collection of blood through established central/ peripheral venous catheter (36592)
- Arterial puncture (36600)
- Paracentesis (32421)
- Unscheduled OP hemodialysis (G0257)



Beneficiary Considerations

Notice of Exclusion



- Providers **may** use the Notice of Exclusion from Medicare Benefits to advise beneficiaries of any potential liability.

- See the following website for Exclusion form
  - http://www.corcoranccg.com/GetFile.aspx?FileID=6f4413de-529a-4c67-8955-6674a3f1efb6
    - See next slide for samples of "Notice of Exclusion from Medicare Benefits"
    - Recommended to be given to the patient when applicable before OP services though not mandatory since the information is contained in their Medicare Handbook

Notice of Exclusion(s)

Part of the form only

Notice of Exclusion from Medicare Benefits

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.
- When you receive an item or service that is not a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

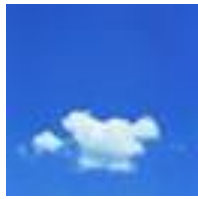
Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $_____**)

Medicare will not pay for:

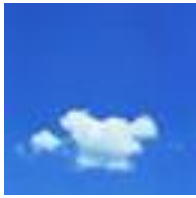
Beneficiary considerations

- The beneficiary in an Observation status is liable for a coinsurance charge equal to 20% of the hospital's customary charges for the services
  - PPS hospitals are paid under the hospital Outpatient Prospective Payment System (OPPS)
  - PPS hospitals are also subject to the preadmission payment window, a Medicare beneficiary would not be liable for the coinsurance charges for the observation status services when subsequently admitted



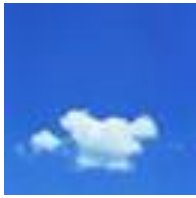
Beneficiary considerations

- Inappropriate use of observation services subjects Medicare beneficiaries to an increased beneficiary coinsurance liability that could have been avoided, had the beneficiary been properly admitted as an inpatient when he/she met criteria
- Beneficiary should be informed of his / her OP observation status because CMS requires participation in Medicare Part B benefits for this service
- Hospitals should discuss the process with registration staff or nursing for after hours on how we will notify the patient/responsible party regarding their responsibility at the beginning of their stay?



Beneficiary considerations

- Beneficiary is responsible for a part B yearly deductible and a coinsurance or copayment for all OP services including those provided while in OP Observation
  - Coinsurance or copayment amount the beneficiary pays for an individual service cannot be more than the current amount the beneficiary pays as the Part A IP hospital deductible. However the total copay can exceed inpatient deductible



- Each Fiscal Intermediary (FI) has a list of medications they do not pay for while in Observation but they mostly consist of all PO medication.

Medications that can be self-administered are not covered under Part B. For safety reasons many hospitals have policies that don't allow patients to bring prescription or other drugs from home. Facility policy should be clear regarding self-administered drugs.

Self-Administered Drugs in OP Setting

- People with Medicare often need self-administered drugs in hospital outpatient settings, like the emergency department, observation units, surgery centers, or pain clinics.

- Medicare Part B does not cover drugs that are usually self-administered by the patient unless the statute provides for such coverage.

- The statute explicitly provides coverage, for blood clotting factors, drugs used in immunosuppressive therapy, erythropoietin for dialysis patients, certain oral anti-cancer drugs and anti-emetics used in specific situations.

- Drugs not falling into the category listed in the previous sentence, are billable to the patient and do not require an Advanced Beneficiary Notice (ABN). Providers should identify these drugs in order to bill as non covered.

Self-Administered Drugs in OP Setting

- All pharmacy drugs and IV solutions are assigned a revenue code of 250 to 269
- Providers assign a specific revenue code, (i.e. 259) to all drugs that can be self-administered.

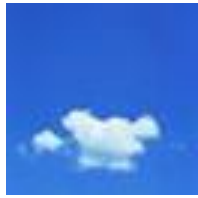
- The CDM is then assigned codes specific to payor including Medicare signifying them that those are non-allowable charges
  - Obtain assistance from CDM consultants to assist in the process as needed

- By assigning one of these revenue codes, facilities can automatically file charges as non-covered on outpatient claims, without reviewing the patients' itemized account.
  - These drugs are covered when provided to an inpatient.

Self-Administered Drugs in OP Setting

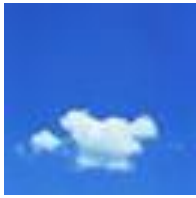
- Outpatient or inpatient drugs and biologicals that are put directly into an item of durable medical equipment or a prosthetic device are covered under Medicare (See Benefit Policy Manual Chapter 15 Section 110.3)

- **Exceptions to outpatient self-administered drugs:**
  - Insulin provided to a patient in a diabetic coma. Use value code A4 and revenue code 637
  - Drugs provided during an outpatient operative session. (i.e., eye drops or ointments provided during cataract surgery)
  - Oral anti-emetic drugs, Q0163 . Q0181 (See revenue code 636)
  - Oral chemotherapy (see revenue code 636)
  - Oral immunosuppressant drugs (see revenue code 636)
  - Drugs needed for use of DME or Prosthetic/Orthotic device



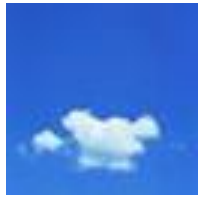
- Hospitals are expected to bill the patients for drugs that are not covered by Medicare
  - Patients should be notified of their responsibility in advance of the service
  - Medicare states that for safety reasons, many hospitals have policies that don't allow patients to bring prescription or other drugs from home but that they still will be billed.
  - If no attempt to charge the patient as per policy for any patient billable services, it is not appropriate to add the cost to the cost report

- **Take home drugs from All Facilities for Medicare Beneficiaries**
  - Revenue code 253 is not covered by Medicare. If drugs are dispensed to an outpatient for use at home - the beneficiary is responsible for the charges.
- Drugs and biologicals furnished by a hospital to an inpatient for use outside the hospital are, in general, not covered as inpatient hospital services.
  - However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital, and a limited supply is required until the patient can obtain a continuing supply, the limited supply of the drug or biological is covered as an inpatient hospital service. These drugs should be billed under 250.



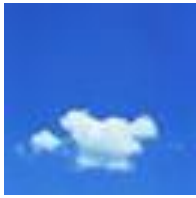
Self-Administered Drugs in OP Setting

- Medicare drug plans (Part D) may provide some limited reimbursement for self-administered drugs.
  - Generally, Medicare Part D plans will only be able to provide in-network reimbursement for self-administered prescription drugs that meet the following criteria:
  - They are covered on the Part D plan's formulary (or covered by an exception).
  - They aren't routinely obtained from out-of-network providers, such as the hospital or emergency department.
  - They couldn't have been reasonably obtained through an in-network pharmacy.
  - They're supported by receipts and documentation.



Self-Administered Drugs in OP Setting

- Hospitals must choose a consistent process, write a P&P and communicate with the staff:
  - ✓ Notify the patient of their responsibility for self-administered drugs – see website below for sample CMS patient information material on the subject
    http://www.medicare.gov/Publications/Pubs/pdf/11333.pdf
  - ✓ If hospitals allow for patient to bring self-administered drugs in, the P&P should include the following:
    - What is the process to ensure medication safety
      - Medication in the original container
      - Who will review content - ? Pharmacist and what to do when not on duty – house supervisor, Hospitalist, ED physician?
  - ✓ What do we do if patient does not bring medication in original container? Do we still let him/her self-administer their own medication and have him/her/responsible party sign a release of liability form? Or do we refuse to have that occur?



Do we need to give an ABN?

- The intent of the ABN form is to explain to patients that a provider anticipates Medicare will not pay for certain services.
  - Patients will be responsible for payment to providers when they (or their representatives) opt to receive these services.

- Use of the ABN form is more common in outpatient settings, hence appropriate to be issued with Observation which is an OP service
  - For example, an observation patient who refuses to leave the hospital may receive an ABN form that explains Medicare will not pay for custodial care
  - The hospital must give proper notice to the beneficiary in advance of any custodial care provided in order to charge the beneficiary for the custodial care.

Do we need to give an ABN?

- CMS introduced a new ABN effective November 1, 2011
  - ABN forms with a March 2008 release date issued on or after November 1, 2011 will be invalid.
  - https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
  - https://www.cms.gov/BNI/02_ABN.asp

Do we need to give an ABN?

- See part of new ABN below

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Informing The Patient

- Patient's should be clearly notified of their responsibilities:
- Consider the following:
  - Create a special consent form for Observation which would be signed by the patient/responsible party.
    - Explain that Observation is an OP service and whether they will be responsible for payment based on payor
    - Note that Medicare beneficiaries are responsible for 20% of charges…. that their co-insurance may cover…
    - Responsible for self administered drugs such as…..and explain their options – may give the Notice of Medicare Exclusion as discussed earlier)
    - Have a bullet for them to sign that they are taking responsibility if they choose to bring their own meds in (if allowed at your hospital)

- Consider providing community education using:
  - Framed sign explaining Medicare's rule and post it in ED and OP procedure areas.
  - Others are creating a simple pamphlet to notify patients of their Observation status and responsibility
    - Pamphlet is provided with ED visits to educate the community
    - It also instructs the Medicare beneficiaries to bring in their home meds…
  - Don't forget to have educational material to the point, short, large print, clear and who can they ask if they have any questions.
  - Also recommended is a letter to notify the IP when they were deemed not meeting IP criteria and the physician has changed their level of care to Observation which is an OP service ……..

Observation Chart Content

Observation Chart Content for Payment Purpose, FI MAC or RAC Review

- ED form when placed in Observation through ED
- Physician order sheet
- Physician progress form (admitting note must support reason for Observation as discussed earlier) and medical necessity for orders must be documented
- Nursing Admission form / note to include:
  - Admission time, admitting vital signs, chief complaint and condition on admission
  - Modified problem focus assessment if patient came from the ED where a nurse did the full assessment (which needs to be part of this chart)
    - Complete full assessment if patient was placed in Observation directly from the community
  - Full Skin Assessment and Fall Precaution Need Assessment
  - List of medications (include dosages and frequency) patient is taking on a regular basis
  - Discharge planning assessment and document needs

Observation Chart Content for Payment Purpose, FI MAC or RAC Review

- Nursing progress notes – free hand notes when monitoring, assessments and treatments occur as well as discharge status
  - Recommended reassessment based on reason for Observation every 1 to max 2 hrs
- MAR and V/S form
- Results of ancillary tests from ED and/or Observation as well as procedure and therapy reports
- Physician discharge progress note with discharge instruction and follow-up
- Copy of discharge instructions

Observation Policies & Procedures

Policy and Procedure Observation items

- The Observation patient's medical record must include
  - The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
  - The physician order to "place in outpatient Observation……"
  - A history and physical giving pertinent medical findings and rationale for Observation status
  - The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care
  - Physician and nursing progress notes written with sufficient frequency and content to specify how the patient responds to care.

contd.

Policy and procedure Observation items

- Documented appropriate and timely interventions which include the delivery of appropriate diagnostic and therapeutic services based on the patient's condition.
- When appropriate, the progress notes must state "continue outpatient observation" and what aspects of the patient's condition warrant extended Observation.
- Address abnormal test results.
- Document reassessment of the patient's medical, physical, psychological and social needs with appropriate referrals.
- The medical record will reflect patient teaching to include medication instructions, dietary advisements and wound care instructions.

contd.

Policy and procedure Observation items

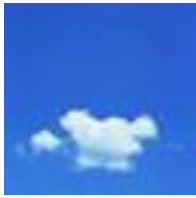
- Documented plan for appropriate follow-up care.

- Care Manager/UR to direct questions concerning the appropriate utilization of the observation patient with physician as soon as possible and refer to Medical Director and to Administration as needed

- Care Management to call the patient's physician, if after 24 hours of being placed in Observation (usually done before leaving for the evening), the medical record does not reflect orders to continue outpatient observation, admit or discharge the patient.

Documentation considerations

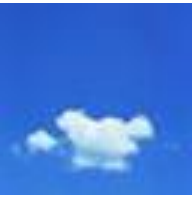
- CMS Medical reviewers look for the following to determine medical necessity and intensity of the service
  - Does the physician's order accurately and clearly reflect the care setting required?
  - Does the documentation support the medical necessity of the services provided?
  - Does the documentation include sufficient rational to support the level of care ordered?



How Can Physicians Help?

How can physicians help?

- Documented order for OP observation status
  - Remind ED physician when discussing plan
- Repeat visit / discharge visit – decision by the "24th hour" as to what the next step will be if patient is still in Observation
- Discharge progress note, plan of care and discharge instructions
- The decision to place into an Observation status is the responsibility of the physician, not the hospital. We do ask that physicians work closely with the hospital – at this time the physician still gets paid for visits to patient who's admission has been denied, the hospital does not – this may change
  - Imperative to educate both ED physicians and nurses and/or supervisors when available regarding Observation criteria
  - Care managers should round on Observation patients first thing in a.m. for utilization review purpose



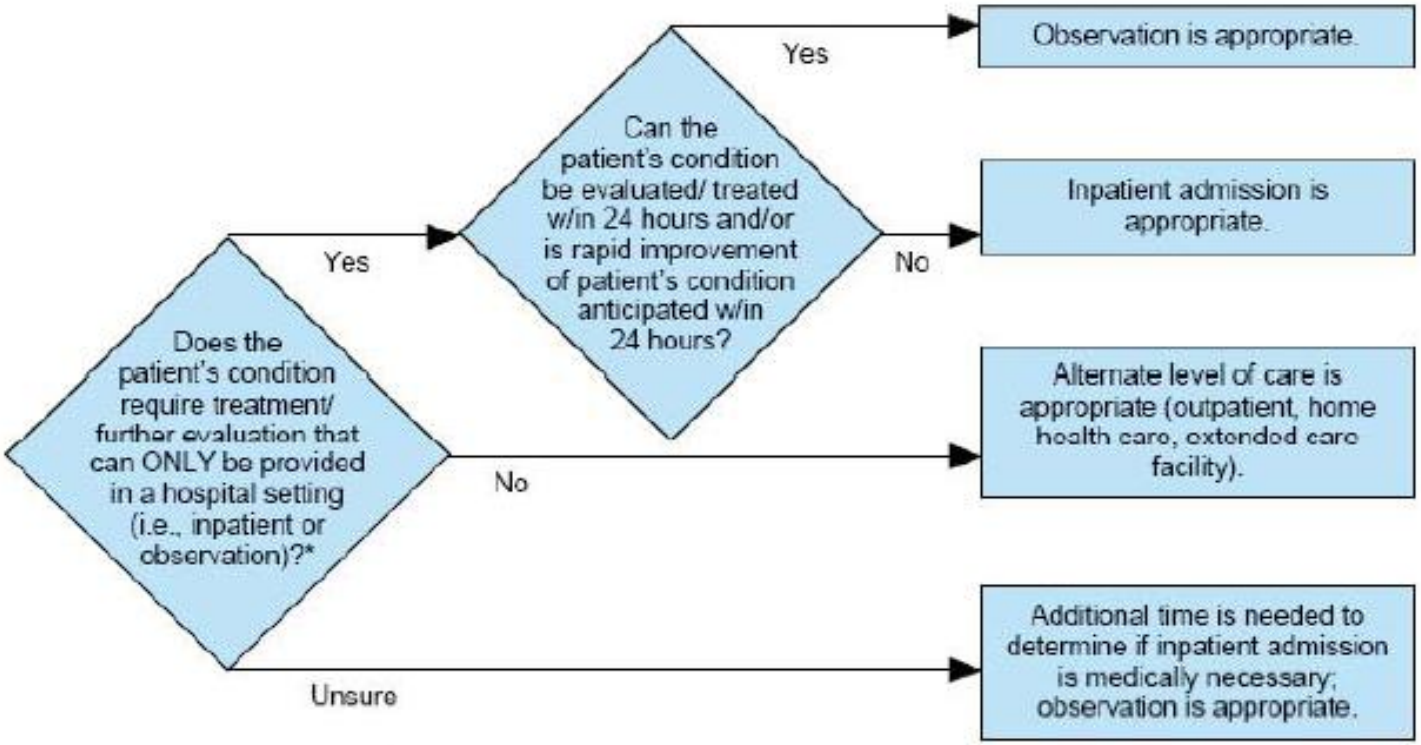
Observation Utilization Decision Tree

STROUDWATER ASSOCIATES

TMF Health Quality Institute

MEDICARE PATIENTS: Observation or Inpatient Admission?

To aid the physician in determining when observation may be appropriate, TMF Health Quality Institute (TMF) has developed a decision tree outlining the thought process for determining whether observation or inpatient admission is appropriate. TMF hopes that this tool will be valuable to physicians when having to make this decision.



* The decision to admit a patient as an inpatient requires complex medical judgment including consideration of the patient's medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents.

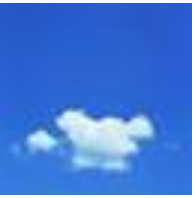
Medical necessity documentation is imperative

- **Factors contributing to medical necessity denials:**
  - Incomplete documentation (blank fields)
  - Inconsistent documentation
  - Illegible documentation
  - Lack of documentation to support change in patient's condition or care
  - Addendums must be provided in accordance with accepted standards for amending documentation

Physician Billing for Observation Status

Hospital Observation physician billing description

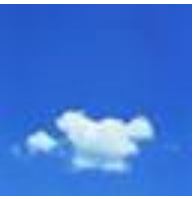
- For reporting purposes, intra-service time for these services is defined as unit / floor time, which includes:
  - Time physician spent on the unit and at the bedside rendering services – this includes:
    - Chart review
    - Patient exam
    - Writes notes and communicates with other professionals
    - Communication with family
  - Pre and post time is not included in the time reported (e.g.: reviewing pathology and/or radiology reports in another part of the hospital) but it was included in calculating the total work of typical services reported in physician surveys



Who can bill initial Observation care?

- Contractors pay for initial observation care billed by only the physician who placed the patient in Observation and was responsible for the patient during his/her stay in Observation.

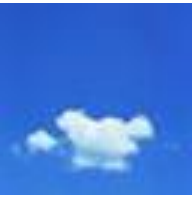
- A physician who does not have inpatient admitting privileges but who is authorized to place a patient to Observation status may bill these codes - such as an ED physician because Observation is an OP service



- Payment for an initial Observation care code is for all the care rendered by the admitting physician on the date the patient was placed in observation

Who can bill initial Observation care?

- For a physician to bill the initial Observation care codes, there must be a medical Observation record for the patient which contains:
  - Dated and timed physician's admitting orders regarding the care the patient is to receive while in Observation,
  - Nursing notes, and
  - Initial and other progress notes as applicable prepared by the physician while the patient was in Observation status.

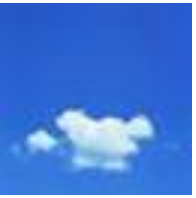


- Documentation identifying the admission and discharge notes were written by the billing physician.

- This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.

Who can bill initial Observation care?

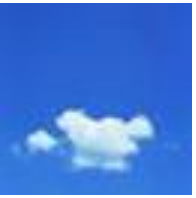
- All other physicians who see the patient while he or she is in Observation must bill the office and other outpatient service codes or outpatient consultation codes as appropriate for the payor in question, when they provide services to the patient.



- Medicare does not accept consultation codes

- For example, if an internist places a patient to Observation and asks an allergist for a consultation on the patient's condition, only the internist may bill the initial Observation care code. The allergist must bill using the outpatient code that best represents the services he or she provided. The allergist cannot bill an inpatient consultation since the patient was not a hospital inpatient.

Physician billing



- If patient was seen in ED, placed and followed in Observation status by the same physician, bill ED professional fee or initial Observation assessment only but not both
- If patient seen in physician's office then placed in Observation status, the physician may choose to bill for office visit or initial Observation care code
- If patient is referred to primary physician from ED and both agree to the need for Observation, the ED physician may bill for the ED visit and the primary physician or hospitalist who will be following the care while in Observation may bill for Observation as per the extent of the service as long as they are not from the same practice.

Q: ED MD places pt. in Observation at 6 pm and bills for ED visit - PCP sees patient later that day or the next day the next day, how should he/she bill:

A: If the patient will not be discharge that day, the PCP bill for an initial observation care as long as the two physicians are not from the same practice

If the patient is to be discharged that day, the PCP bills for an admit/discharge same day as appropriate again, as long as the two physicians are not in the same group.

Q: What if the ED MD/DO placed the pt. in Observation at 1:00 am under the care of Dr. X and bills ED visit as above - PCP comes in am – can he/she bill subsequent visit since it's the same day?

A: If the ED MD/DO bills an ED visit, and not for the admission to Observation, then the scenario is the same. As above The provider taking responsibility for the patient and doing the initial "observation " H&P bills for an initial and not the subsequent unless discharging the patient on the same day.

Q: The PCP at my hospital does not see the patient on the day he was placed in Observation even though the ED billed for the ED visit only – that creates problems because the patient may go a long time without seeing a physician – in this case – the day after the ED visit. Should the PCP wait that long?

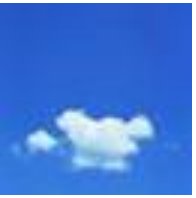
A: This usually happens when the physician is not aware that he/she can bill for an initial admit on the same day as the ED visit as long as the ED MD/DO billed for ED and the ED MD/DO and the PCP are not from the same practice.

- Even though the previous scenarios are for PCPs, the process is the same when the ED provider and the MD/DO taking responsibility for the patient in observation do not belong to the same group (usually hospitalists).

- Expect to see denials for the admit/discharge same day of the date span on the claim that includes the ED date of service (DOS). These will need to be appealed with the H&P notes showing the actual H&P DOS.

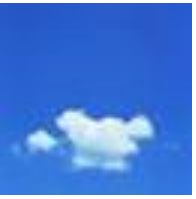
Physician billing

- Observation D/C and Acute Care Admission cannot be both billed on the same day
- Physicians may bill for an initial Observation care and an Observation D/C code if D/C is on other than initial date of "observation status"
- Following instructions (on next slides) affects physicians and qualified non-physician practitioners (NPPs) who can submit claims to Part A/B Medicare Administrative Contractors (A/B MACs) and carriers for hospital Observation services provided to Medicare beneficiaries during a hospital visit



Physician billing

- Physicians and qualified NPPs should report Initial Observation Care using a code from CPT code range 99218 – 99220 when the observation care is less than 8 hours on the same calendar date.
  - According to Medicare guidelines, when doctors have patients in observation for less than eight hours on the same calendar date, they should bill an initial observation care code (99218–99220) but no discharge code (99217).



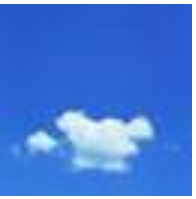
- Physicians and qualified NPPs *should not report* an Observation Care Discharge Service (CPT code 99217) when the observation care is less than 8 hours on the same calendar date.

- Physicians and qualified NPPs should report Initial Observation Care using a code from CPT code range 99218 – 99220 and an Observation Care Discharge Service (CPT code 99217) when the patient is placed in a bed for observation care and discharged on a different calendar date.

Physician billing

- Physicians and qualified NPPs should report Observation Care Service (Including Admission and Discharge Service) using a code from CPT code range 99234 – 99236 when the patient is placed in Observation care for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date.

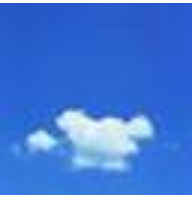
- Physicians and qualified NPPs should report Office or Other Outpatient Visit using a code from CPT code range 99211 – 99215 for a visit before the discharge date in those rare instances when a patient is held in Observation care status for more than two calendar dates.



Admission to IP status from Observation

- If the same physician who placed a patient in Observation status also admits the patient to inpatient status from Observation before the end of the date on which the patient was placed in Observation, Medicare will pay only an initial hospital visit for the evaluation and management services provided on that date. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service.

- In other words, the physician may not bill an initial Observation care code for services on the date that he or she admits the patient to inpatient status.



Admission to IP status from Observation

- If the patient is admitted to inpatient status from Observation subsequent to the date of patient being placed in Observation, the physician must bill an initial hospital visit for the services provided on that date.

- The physician may not bill the hospital Observation discharge management code (code 99217) or an outpatient/office visit for the care provided in Observation on the date of admission to inpatient status.

Observation during Global Surgical Period

- The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, and 99220, 99234, 99235, 99236) services unless the criteria for use of CPT modifiers "-24," "-25," or "-57" are met. Contractors must pay for these services in addition to the global surgical fee only if both of the following requirements are met:
  - The hospital observation service meets the criteria needed to justify billing it with CPT modifiers "-24," "-25," or "-57" (decision for major surgery); and
  - The hospital observation service furnished by the surgeon meets all of the criteria for the hospital observation code billed.

Two Hospital Visits Same Day

- Contractors pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. The inpatient hospital visit descriptors contain the phrase "per day" which means that the code and the payment established for the code represent all services provided on that date.

- The physician should select a code that best reflects all services provided during the date of the service.

Hospital Visits Same Day but Different Physicians

- In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, carriers do not pay physician B for the second visit. The hospital visit descriptors include the phrase "per day" meaning care for the day.

- If the physicians are each responsible for a different aspect of the patient's care, pay both visits if the physicians are in different specialties and the visits are billed with different diagnoses.

Hospital Visits Same Day but Different Physicians

Q: What code should a hospitalist bill after being called to the ED for a possible admission when the patient is ultimately discharged and not admitted?

A: In the scenario above, observation guidelines are not met since there is no physician order for observation status. So charging an observation same-day admission and discharge is not correct

Under Medicare guidelines (and many private payers) , physicians should bill these services using emergency department visit codes (99281-99825).

But if you're billing a payer that still pays consult codes, and the hospitalist has been asked for an opinion on whether the patient needs to be admitted - In that case, use the office or other outpatient consultation codes (99241-99245).

Kristy Welker is an independent medical coding consultant based in San Diego

Physician documentation

- Physicians and qualified NPPs should:
  - Document the medical record to satisfy the evaluation and management guidelines for admission to and discharge from Observation care or inpatient hospital care
  - Note that the documentation requirements for history, examination and medical decision making should be met
  - Document his/her physical presence
  - Document his/her personal provision of Observation care
  - Document the number of hours the patient remained in the Observation care status
  - Personally document the admission and discharge notes though an admitting physician may designate another physician to complete the discharge summary (often seen in a hospitalist model)

Physician Observation Billing Codes Synopsis	
Code	Description
	Initial Observation Care - Admission: less than 8 hours and D/C on same calendar date
99218	Low severity
99219	Moderate severity
99220	High severity
99234 99235 99236	Use when the patient is placed in Observation care for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date.
	Observation care discharge code
99217	Use 99217 for discharge care when Observation admission is > than 8 hrs and discharge date is on a different day than the date the patient was placed in Observation
	Do not use when Observation is < than 8 hrs and discharged on the same calendar date as the admission
	Observation Care ***AND*** Observation D/C Codes
99218 99219 99220 99217	Use 99218-99220 for Admission and 99217 for Discharge for observation care > than 8 hours and D/C on a different date than when the patient was placed in Observation

Physician Observation Billing Codes Synopsis	
Code	Description
	Observation care > than 48 hrs
99211 99212 99233 99214 99215	Use 99211-99215 (office visit) for Observation care for those rare occasions when the patient remains in Observation longer than 48 hrs
	Initial Observation Care and Admission
99218 99219 99220	Cannot use Initial Observation Care codes on the same day as an IP admission
99218-99220 and 99221-99223	Use 99218 to 99220 for initial Observation Care and 99221 to 99223 for Initial Hospital visit if patient is admitted the calendar date following the date the patient was placed in Observation

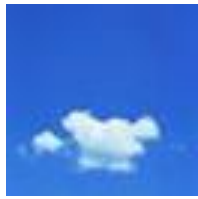
Time For An Action Plan….

Are you at risk?

- Does the CMgr/UR have available resources to serve as guidelines for the right level of care (InterQual, Milliman Roberts)
- Do we have Medical UR Director/Advisor?
- Do we wrongfully allow auto-conversion,
  - Placed in Observation and automatically admitted after 24 hours? (should not allow)
  - Automatic recovery room to Observation? (should not allow)
- Are staff oriented to Observation UR when Case Manager/UR not in-house? – Do we have a cheat sheet for
  - Delayed assessment of patient
  - Weekend admissions
- Are we applying code 44 (from IP to Observation) as required
- Do we ensure NO start of Observation without physician orders?
- Do we ensure no start of billing for direct placement in? Observation from home/NH until physician comes in to evaluate the patient?
- Do we have an early process to evaluate and initiate changes to patient status

What is your risk plan?

- Do we have somebody appointed to calculate the hrs to be billed and do they know the dos & don'ts?
- Do we discuss areas where we are at risk
- Do we educate physicians, nursing, case manager, coders and billers
- Do we audit charts for
  - Dated and timed orders for specific level of care
  - Meeting medical necessity
  - Automatic conversions
  - Ensure differentiation between IP and OP only procedures
  - Are correct billing codes used for hospital and physician if we bill for them
  - Do we have correct D/C codes
  - Infusion and procedure documentation
  - Active observation procedures subtracted
- Does nursing have the tools needed to document? Do they document observations in relations to the reason the patient was put in Observation and/or the effects of the treatment(s)
- Do we inform staff of audit findings – do we graph and celebrate improvement?

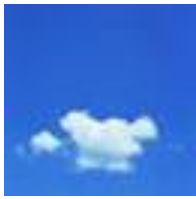


What is your risk plan?

- Do we teach nursing as to why they have to document the way they do
- Do we develop action plan to maintain compliance
- Does care management or other department track data to identify issues and celebrate when meeting goals (by month, compared to same month last year, FYTD and compared to FYTD last year – do we analyze the data and work with PI/QI
  - # of patients placed in Observation
  - # of total hours /24 to = days/month and YTD
  - # of 1 and 2 day IP admissions (separately)
  - # of IP changed to Observation status (condition code 44)
    - Due to UR review
    - Due to clerical errors
  - # of Observation who end up being admitted
  - # of ED re-visits within 72 hrs – should they have been placed in Observation?
  - # of Observation return within 7 days – should they have been admitted
  - # of patients not meeting criteria but kept at the hospital

PI Action Plan

- Create a team to review this presentation and get together to discuss by _____
- Make a list of the known issues and potential issues
- Have everyone write down their questions/comments
- Meet on set date to discuss questions/concerns including the slides regarding the risk of doing nothing etc…
- Feel free to email Mary G with questions for further clarification – mguyot@stroudwater.com
- Develop an action plan based on the needs identified
- Set date and time for next meeting and expect all responsible party to have completed their tasks



PI Action Plan

- Agree on new processes
- EDUCATE staff
- **Remember, it's not what you Expect, it's what you Inspect** so do on-going "inspection"
- Do SOMETHING with your findings – great data collection is worthless if not used to improve processes
- Track RAC outcomes by physicians and share with them – how else will they know?

A STITCH IN TIME SAVES NINE !!!

Some say we do not have time to meet and fix all the concerns .

Performance improvement says – "we do not have the time NOT TO FIX or prevent the issue from occurring."

Mary Guyot, Principal mguyot@stroudwater.com

207-650-5830 (mobile)